



# Army Pain Management Task Force

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**Findings-Recommendations-Way Ahead**

**COL Chester “Trip” Buckenmaier, MC**

Unclassified  
(Information)





# Pain Management Task Force



**“What an infinite blessing.”**







# Pain Management Task Force



## 21<sup>st</sup> Century Evacuation Realities

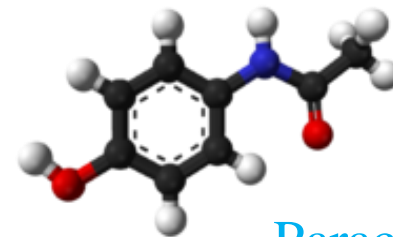




# Pain Management Task Force



## Novel pain control methods and equipment



Paracetamol



# Pain Management Task Force







## Mission

To provide recommendations for a MEDCOM **comprehensive pain management strategy** that is **holistic**, **multidisciplinary**, and **multimodal** in its approach, utilizes **state of the art/science** modalities and technologies, and provides **optimal quality of life** for **Soldiers and other patients** with acute and chronic pain.

» *from Army Pain Management Task Force Charter; signed 21 Aug 2009*

## Vision Statement

**Providing a Standardized DoD and VHA Vision and Approach to Pain Management to Optimize the Care for Warriors and their Families**

**"Standardize to Optimize"**



# Pain Management Task Force



## Task Force Process

- TSG appointed BG Richard Thomas, Assistant Surgeon General for Force Projection, as the TF Chairperson
- Air Force, Navy, and Veterans Health Administration appointed TF representatives

## TASK FORCE

Army Reserve	National Guard	M&RA
TMA/Health Affairs	Warrior Transition Command	DCOE
Behavioral Health	Case Management	Integrated Medicine
Nursing	Occupational Therapy	Pain Management
Pharmacy	Physical Therapy	PM&R
Primary Care	Social Work	Family Medicine



# Pain Management Task Force



## Site Visit Map

**WESTERN Region**

**NORTHERN Region**

- Army
- VA
- Navy
- Civilian
- Air Force

**PACIFIC Region**

**SOUTHERN Region**

**EUROPEAN Region**

- 1 Fort Lewis (MAMC) & Puget Sound VA & Univ of Washington & Swedish Hospital
- 2 Fort Drum (GAHC)
- 3 San Antonio VA, & Wilford Hall & Fort Sam Houston (BAMC)

- 4 Fort Carson (EACH)
- 5 Fort Bliss (WBAMC) & Fort Hood (CRDAMC)
- 6 Tampa VA & Univ of Florida
- 7 Balboa Naval Hospital) & Travis AFB & Scripps Center

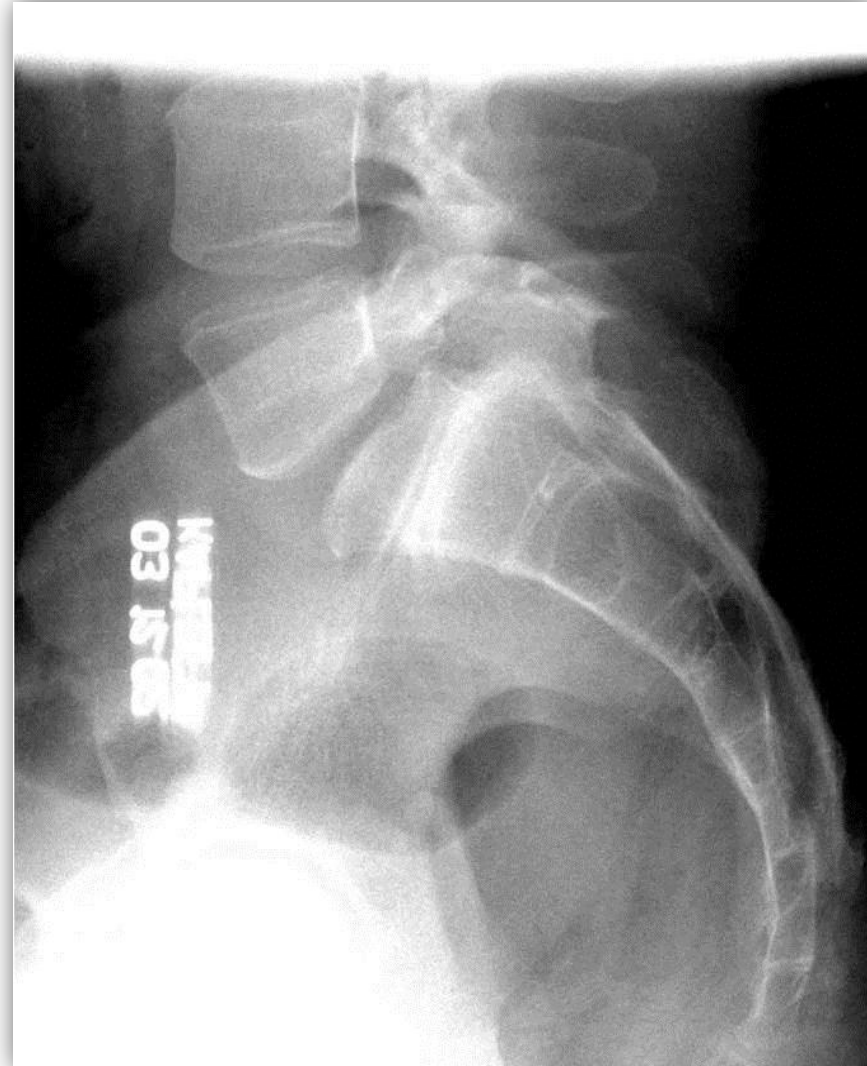
- 8 Landstuhl (LRMC) & Baumholder AHC
- 9 Duke Univ & Camp Lejeune & Fort Bragg (WAMC)
- 10 Fort Campbell (BACH)

- 11 Honolulu (TAMC)
- 12 Fort Gordon (DDEAMC) & Fort Stewart (WACH)
- 13 White River Junction VA
- 14 Walter Reed (WRAMC)





# The Beginning of Pain for Veterans: Blast/Projectile Trauma and Axial Load Injuries





# VHA National Pain Management Strategy

- Strategy initiated by the Undersecretary for Health in 1998
- Pain Management Directive 2009-053 recently published
- Three top priorities
  - Implement stepped pain care model
  - Integration into Medical Home
    - Expand Integrative Primary Care
  - Build partnership with DoD



## Organization, VHA Pain Management Strategy

### National Pain Management Office

Director (Robert Kerns PhD), Deputy Director (Rollin Gallagher MD, MPH)



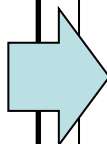
#### ***National Coordinating Committee***

##### **Education**

- Conferences (National)
- Websites materials

##### **Research**

- Standing Subcommittee -
- Journal Special issues  
*JRR&D, Pain Medicine*
  - HSRD / RR&D Merit Awards, Training Awards
  - PRIME Center



#### ***23 VISN Pain Points of Contact***

##### **Facility Pain Points of Contact**

##### **Facility Pain Coordinating Committees**

**Facility Pain Clinical Programs**  
Primary care<< >>Pain Medicine  
<< >>Pain Rehabilitation





# Pain Management Task Force



## Frequency of Possible Diagnoses among OEF and OIF Veterans

Diagnosis (Broad ICD-9 Categories)	Frequency	Percent
Infectious and Parasitic Diseases (001-139)	68,569	13.5
Malignant Neoplasms (140-208)	5,809	1.1
Benign Neoplasms (210-239)	25,491	5.0
Diseases of Endocrine/Nutritional/ Metabolic Systems (240-279)	135,250	26.6
Diseases of Blood and Blood Forming Organs (280-289)	14,342	2.8
<b>Mental Disorders (290-319)</b>	<b>243,685</b>	<b>48.0</b>
<b>Diseases of Nervous System/ Sense Organs (320-389)</b>	<b>202,298</b>	<b>39.8</b>
Diseases of Circulatory System (390-459)	94,671	18.6
Disease of Respiratory System (460-519)	116,308	22.9
Disease of Digestive System (520-579)	172,462	33.9
Diseases of Genitourinary System (580-629)	63,421	12.5
Diseases of Skin (680-709)	93,635	18.4
<b>Diseases of Musculoskeletal System/Connective System (710-739)</b>	<b>265,450</b>	<b>52.2</b>
<b>Symptoms, Signs and Ill Defined Conditions (780-799)</b>	<b>233,443</b>	<b>45.9</b>
Injury/Poisonings (800-999)	130,300	25.6

\*These are cumulative data since FY 2002, with data on hospitalizations and outpatient visits as of September 30, 2009; Veterans can have multiple diagnoses with each health care encounter. A Veteran is counted only once in any single diagnostic category but can be counted in multiple categories, so the above numbers add up to greater than 508,152; percentages add up to greater than 100 for the same reason.

Cumulative from 1st Quarter FY 2002 through 4th Quarter FY 2009





## Prevalence of Chronic Pain, PTSD and TBI in a sample of 340 OEF/OIF veterans with polytrauma

**Chronic Pain**

N=277

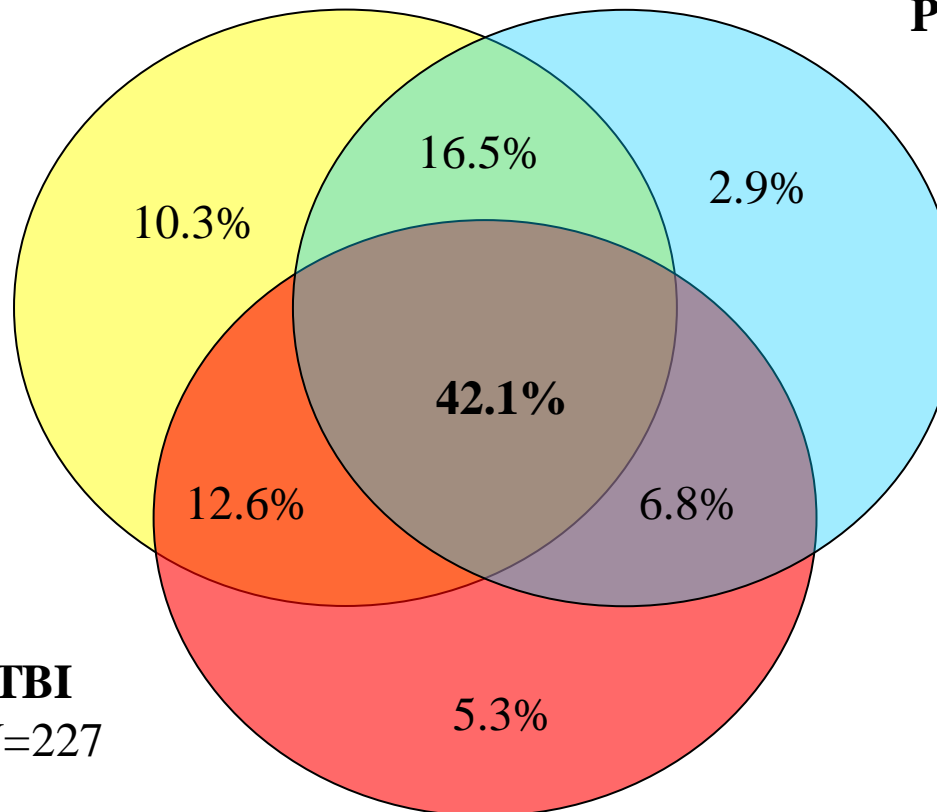
81.5%

**PTSD N=232**

68.2%

**TBI**  
N=227

66.8%



Lew, Otis, Tun et al., (2009). Prevalence of Chronic Pain, Post-traumatic Stress Disorder and Post-concussive Symptoms in OEF/OIF Veterans: The Polytrauma Clinical Triad. *JRRD*.

# Beginning to End: The Chronic Pain Cycle

## Pathophysiology of Maintenance:

- Radiculopathy
- Neuroma traction
- Myofascial sensitization
- Brain, SC pathology (atrophy, reorganization)

## Pathology:

- Muscle atrophy, weakness;
- Bone loss;
- Immunocompromise
- Depression
- Substance abuse

## Psychopathology of maintenance:

- Encoded anxiety dysregulation
  - PTSD
- Emotional allodynia
- Mood disorder

## Acute injury and pain

## Central Sensitization

- Neuroplastic changes

## Neurogenic Inflammation:

- Glial activation**
- Pro-inflammatory cytokines
- blood-nerve barrier disruption

## Peripheral Sensitization:

- New Na<sup>+</sup> channels cause lower threshold**

## Disability

- Less active
- Kinesophobia
- Decreased motivation
- Increased isolation
- Role loss
- Sleep disorder

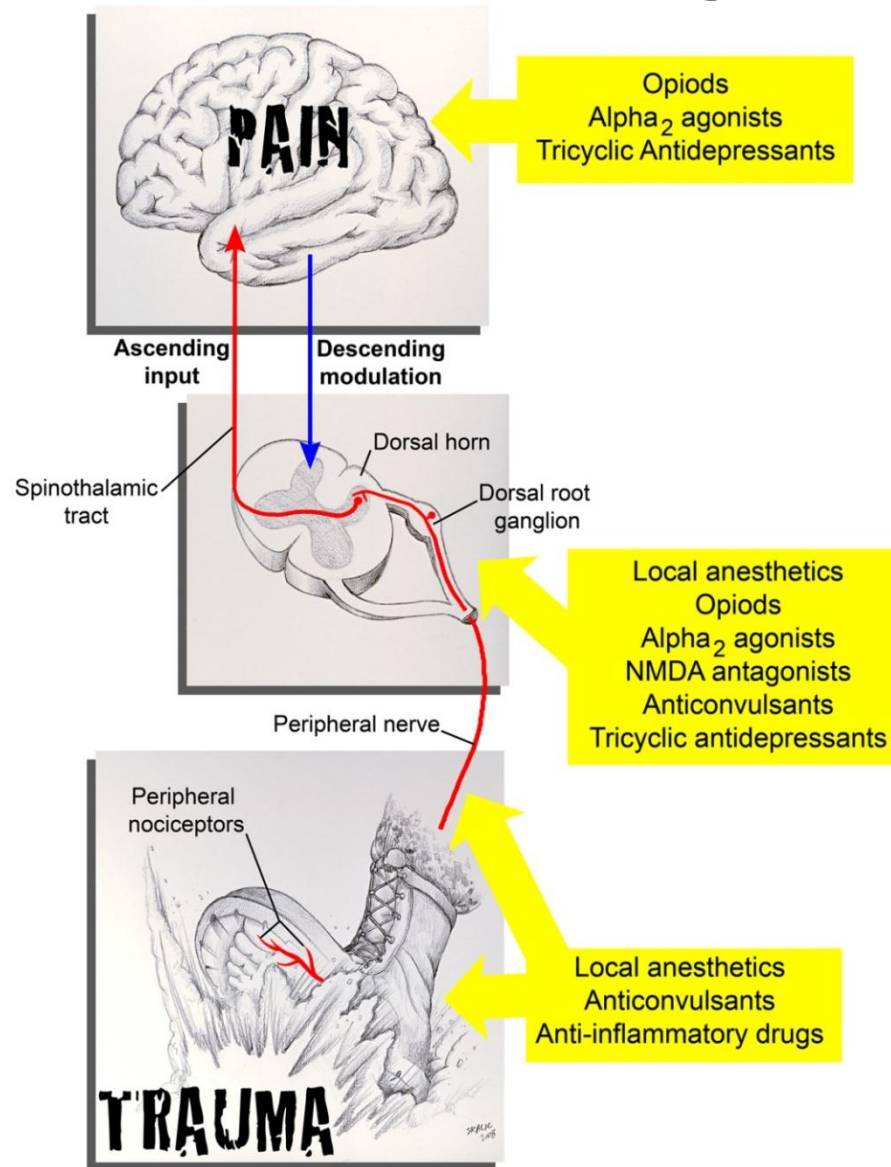


# The key elements in the continuum of pain care

- **Primary prevention:** avoiding injury, nociception, nerve damage
- **Secondary prevention:** after injury / start of disease,
  - minimizing pain's access to the CNS
  - minimizing concurrent augmenting factors (e.g. stress)
  - minimizing the pathophysiologic response of the CNS (e.g. neuroplastic pathophysiology)
- **Tertiary prevention:** Once “chronification” occurs, reducing its negative impact on quality of life by rehabilitation: social networks (love & support), motivation (goals) towards functional restoration, and reversal of neuroplastic damage



## Multimodal Analgesia





# VA Stepped Pain Care

RISK

Comorbidities

Treatment  
Refractory

Complexity

## Tertiary, Interdisciplinary Pain Centers

- Advanced pain medicine diagnostics & interventions
- CARF accredited pain rehabilitation

**STEP  
3**

## Secondary Consultation

- Pain Medicine
- Rehabilitation Medicine
- Behavioral Pain Management
- Multidisciplinary Pain Clinics
- Mental Health & SUD Programs

**STEP  
2**

## Primary Care

- Routine screening for presence & intensity of pain
- Comprehensive pain assessment
- Management of common pain conditions
- Support from MH-PC Integration, OEF/OIF, &
  - Post-Deployment Teams
  - Expanded care management
- Opioid / Pharmacy Management Clinics

**STEP  
1**



# Pain Management Task Force



## TF Site Visit Findings

### BEST PRACTICES

- Integrated Pain Center (TAMC and BalboaNMC)
- Case Management of Pain Patients (Ft Drum)
- Strong Interventional Pain Capabilities at MEDCENS
- Integrated Pain Board (Travis AFB)
- WTU Medication Policies/Initiatives
  - Sole Provider
  - Medication Reconciliation (Ft Campbell, Baumholder, Ft Bragg)
  - WTU Pharmacist (Ft Bliss, Ft Hood, Ft Carson)
  - Embed Pain Mgt Resources in WTU (WRAMC, Ft Bragg)

### EDUCATION

- **Primary Care Providers feel they are ill-prepared to handle “pain patients”** and look to move them to specialty care ASAP
- **Lack of common orientation to pain** among medical staff
  - Taxonomy
  - Practice
- Lack of common orientation to pain among Patients

### EDUCATION

- Many Providers not aware of Clinical Practice Guidelines for pain management
- Clinical Practice Guidelines are not “user friendly”
- MEDCOM not fully leveraging IM/IT capabilities to influence/optimize pain mgt practice
- **Need improved pain assessment tool**
- The perception of working in a system that asks for “A” (quality/satisfaction) but rewards “B” (productivity)

### RESEARCH

- Need to improve translational research for pain management
- **Current research not fully leveraging the interest/capabilities power of clinicians in research**
- We are not able to track sufficient “actionable” pain data for our patients

### CAPABILITIES

- **Lack of predictable pain management capabilities across our MTFs**
- **Lack of standardization not unique to MEDCOM or DoD**
- **Lack of non-medication modalities** for pain mgt
- Overwhelming majority of Providers not satisfied with pain management care received in network



# Task Force Recommendations

## Providing a Standardized DoD and VHA Vision and Approach to Pain Management to Optimize the Care for Warriors and their Families

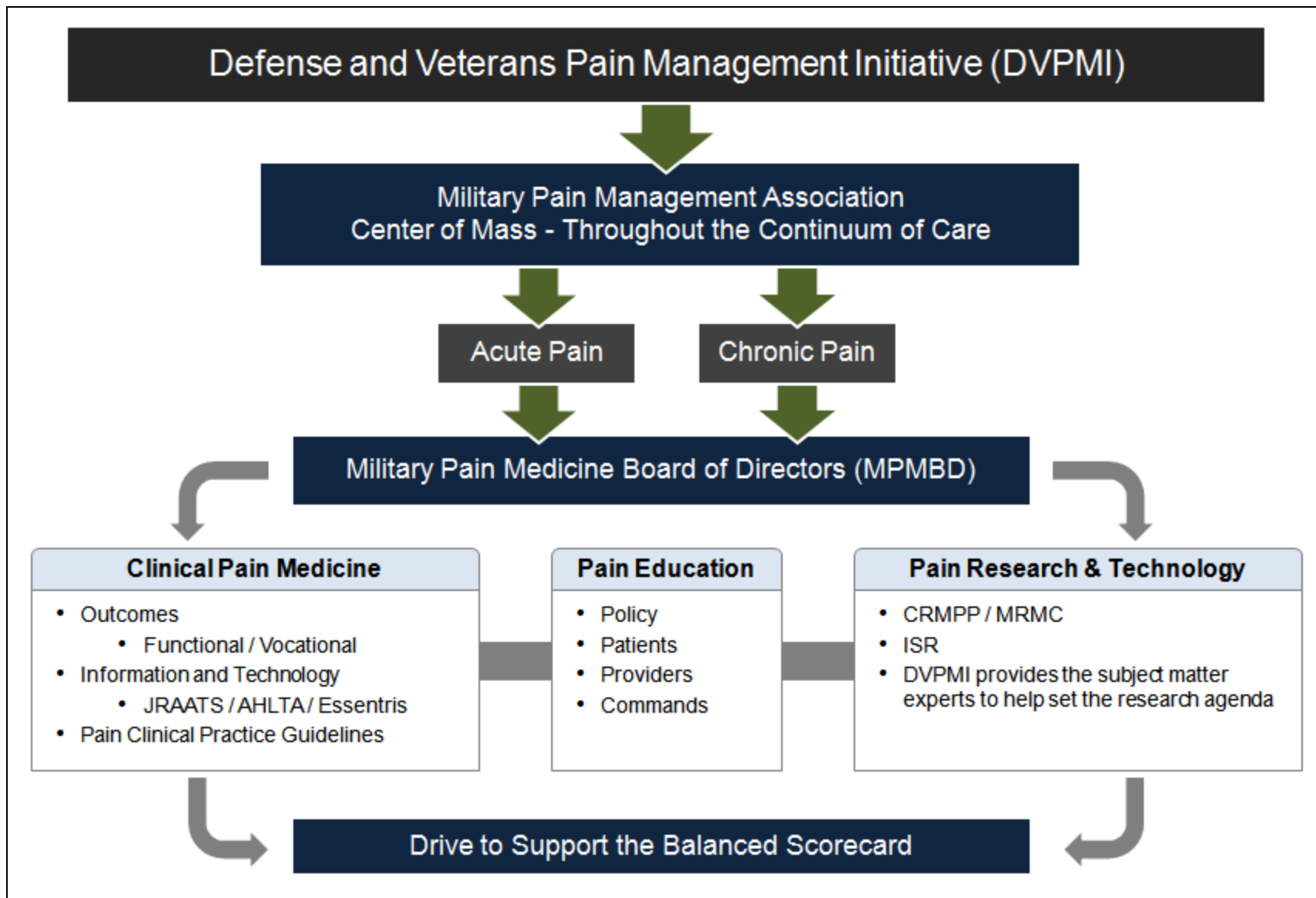
1	Focus on the Warrior and Family - Sustaining the Force
2	Synchronize a Culture of Pain Awareness, Education, and Proactive Intervention (Medical Staff, Patients and Leaders)
3	Provide Tools and Infrastructure that Support and Encourage Practice and Research Advancements in Pain Management
4	Build a Full Spectrum of Best Practices for the Continuum of Acute and Chronic Pain Care, Based on a Foundation of the Best Available Evidence



# Pain Management Task Force



## Army Pain Management Center of Excellence







# Pain Management Task Force



## Thank you

